Veterans Home of California (VHC) Admission Application

APPLICATION PREFACE AND GENERAL QUALIFICATIONS

Welcome to the application process, the path to becoming a resident at one of California's extraordinary Veterans Homes. We encourage all eligible veterans to apply for admission. California's Veterans Homes are operated as an expression of gratitude toward our State's veterans.

To save time, before you start to fill out the application form, check to see that you meet the basic qualifications for admission. In brief, these qualifications are:

1. **You are age 62 or over and/or you have a significant disability.**
2. **You served in the U.S. military and you were honorably discharged.**
3. **You are still able to live independently or you qualify for a higher level of care offered at one of the Homes (contact the Home for clarification on qualifying for a higher level of care).**
4. **You are a California resident.**
5. **You are able to live with and get along with other people in a structured communal environment.**

Further information about the Homes, instructions on filling out the application and the admission process can be found online. Go to www.cdva.ca.gov > click on Veterans Homes > click on Download the Application Package for the Veterans Home of California > click on Information for Applying to the Veterans Home of California. On the website you will also find specific information about each Veterans Home.

If you need additional help completing this application or have questions, you can call any of the phone numbers found on page A-4.

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TABLE OF CONTENTS AND PREFACE

The application package has seven sections. The applicant completes most sections but some are completed by friends, family, and or physicians. This is the first step in entering a State Veterans Home.

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Section B:	Authorization for Use and/or Disclosure of Resident/ Patient Health Information	Applicant
Section C:	Michigan Alcohol Screening Test – Geriatric (MAST-G)	Applicant
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Section G:	Physician's Medical Certificate	Physician

PREFACE

This application should be completed to the best of your ability. It is the first step in gaining admittance to a California Veterans Home. Having a physician complete the Physician's Medical Certificate and receiving copies of your medical records are often time consuming. Contact your physician as soon as possible to set up an appointment to complete Section G.

Usually the slowest part of the application is waiting for your medical records to arrive at the Admissions Office. Section B provides you with a release form to use in requesting your records from hospitals or other health care providers. Even with Section B completed, it is recommended that you obtain copies of your medical records and send them directly to the Admissions Office to avoid delays.

If your application is approved you will be scheduled for admission to a Veterans Home only upon providing the following documents. These documents can be submitted ahead of time with your application package.

A copy of:

- DD Form 214, Certificate of Release or Discharge From Active Duty
- Proof of California Residency, See Section A, page 1, California Residency
- Completed financial disclosure form
- Copies of Medicare card and other health insurance cards if available.

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BACKGROUND INFORMATION

A

Personal Information

Full name _____
Last First Middle

Social Security number_____ Date of birth_____

Driver license number _____ State_____

Home address _____
Street City State Zip Code

Mailing address (if different from above)_____

Home phone _____ Other phone _____

Place of birth_____ U.S. citizen? ☐ Yes ☐ No

If not a U.S. citizen, resident alien number: _____

Are you:_____Male_____Female

Marital Status

Are you currently married? ☐ Yes ☐ No

If yes, please answer the following questions:

How long have you been married to your current spouse?_____

Is your spouse a veteran? ☐ Yes ☐ No

Is your spouse also applying for admission to VHC? ☐ Yes ☐ No

Spouse's full name_____
Last First Middle

California Residency

Initial here _____ I am a bona fide resident of the State of California. **I am submitting a copy** of the following proof of my residency (please check one or more).

Valid California Drivers License

California Department of Motor Vehicle Identification Card

Registered Voter Status

Utility Bill that shows the applicant's residence

Paying California State Income Taxes as a resident

Letter from County Veteran Service Officer or a VA representative

Other: Explain: _____

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BACKGROUND INFORMATION

A

Military Service Information

What name did you serve under in the military?

Full name _____

Last First Middle

What branch of service were you in?_____

What was your military service number?_____

What were your dates of active duty service?

From_____until_____Type of discharge_____

From_____until_____Type of discharge_____

Are you retired from the military? ☐ Yes ☐ No

Are you the surviving spouse of a Medal of Honor recipient or POW? ☐ Yes ☐ No

Veterans' Benefits Information

Have you ever applied for U.S. Department of Veterans Affairs (VA) benefits? ☐ Yes ☐ No

If yes, what is your VA claim number if known? Claim no.:_____

Do you have any service-connected disabilities? ☐ Yes ☐ No

If yes, what is the military disability percentage?_____

Do you receive non-service-connected pension benefits? ☐ Yes ☐ No

Do you or your spouse currently have a Cal-Vet loan? ☐ Yes ☐ No

(Note: On admission, Cal-Vet will be notified.) If yes: Contract no.:_____

Criminal Background Information

UPON ACCEPTANCE, YOU MAY BE FINGERPRINTED AND HAVE A CALIFORNIA DEPARTMENT OF JUSTICE CRIMINAL HISTORY SEARCH CONDUCTED

Have you ever had any criminal convictions? ☐ Yes ☐ No

If yes, provide the following: _____

Date Type of conviction

_____

County State

Do you have any criminal charges pending? ☐ Yes ☐ No

If yes, describe: _____

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BACKGROUND INFORMATION

A

Are you currently on probation or parole? ☐ Yes ☐ No

If yes: _____
Name of probation/parole officer

_____
Address Phone number

_____
County State

Are you required by law to register with local law enforcement? ☐ Yes ☐ No

Are you currently registered with your local law enforcement as required? ☐ Yes ☐ No

If yes: _____
County State

Medical Information

Have you received any medical, psychiatric, alcohol or drug treatment at any medical facility?

☐ Yes ☐ No

If yes, which one(s)?

1. _____
Name Address

_____
City/State Zip Code Dates

2. _____
Name Address

_____
City/State Zip Code Dates

3. _____
Name Address

_____
City/State Zip Code Dates

4. _____
Name Address

_____
City/State Zip Code Dates

5. _____
Name Address

_____
City/State Zip Code Dates

Have you ever applied for admission or lived in any state Veterans Home? ☐ Yes ☐ No

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BACKGROUND INFORMATION

A

If yes, where? _____
Name Address City/State Zip Code

When? From _____ until _____

Comments (add additional sheets if necessary):

_____

_____

_____

_____

_____

_____

Be aware that there are three Homes. If room is unavailable at your first choice that Home will pass your application package including medical information to the second or third choice and that Home should contact you for any additional or updated information.

_____Barstow or check_____I do not wish to apply for this location.
_____Chula Vista or check_____I do not wish to apply for this location.
_____Yountville or check_____I do not wish to apply for this location.

The selected Home(s) may call you to assist in your application. Also, If you need help or have questions about your application please call:

Barstow Admissions Office	760-252-6315
Toll Free	800-746-0606
Chula Vista Admissions Office	888-857-2146
Yountville Admissions Office	800-400-8387

_____ _____
SIGNATURE DATE

Veterans Home of California (VHC) Admission Application

Authorization for Use and/or Disclosure of Resident/Patient Health Information

B

Neither treatment, payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize _____
(NAME OF HOSPITAL OR PHYSICIAN YOU ARE REQUESTING RECORDS FROM)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP)

to disclose to

_____
(NAME OF VETERANS HOME YOU ARE APPLYING TO)

_____
(ADDRESS)

_____
(CITY) (STATE) (ZIP)

Records and information pertaining to

_____
(NAME OF PATIENT) (MEDICAL RECORD NUMBER) (DATE OF BIRTH)

DURATION: This authorization shall become effective immediately and shall remain in effect until (Date)_____or for one year from the date of signature.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party, My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

RE-DISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

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Authorization for Use and/or Disclosure of Resident/Patient Health Information

B

SPECIFY RECORDS: Check the box and initial to specify type of information to be disclosed

☐ MEDICAL INFORMATION_____(specify below)
INITIAL

☐ PSYCHIATRIC INFORMATION
[Cal. Wel. & Inst. Code §5328]

_____ _____
SIGNATURE DATE

☐ DRUG/ALCOHOL INFORMATION
[42 C.F.R. §2.11 & 2.12]

_____ _____
SIGNATURE DATE

☐ RESULTS OF AN HIV BLOOD TEST
(Health and Safety Code section 121020)

_____ _____
SIGNATURE DATE

☐ OTHER INFORMATION_____(specify below)
INITIAL

Specify the records to be disclosed:_____

_____

_____

The requester may use the health information authorized on this form for medical screening purposes only as outlined in Section G as part of their application for admission to a Veterans Home. A copy of this authorization will be given to the requestor.

Signature:_____ Date:____/____/____
Month Day Year

If signed by other than resident/patient, indicate relationship:_____

[Ref. 45 C.F.R. §164.508;Cal.Civil Code §56.11]

Veterans Home of California (VHC) Admission Application

Michigan Alcohol Screening Test - Geriatric

(MAST-G Screening Device – **University of Michigan 1991)**

C

Part of your application to the Veterans Home will be a review of your drinking habits. Alcohol is not allowed in resident's rooms, so we will ask you a few questions about your alcohol use.

Applicant name:_____ Date:_____

1.	After drinking have you ever noticed an increase in your heart beat or beating in your chest?	Yes	No
2.	When talking with others, do you ever underestimate how much you actually drink?	Yes	No
3.	Does alcohol make you sleepy so that you often fall asleep in your chair?	Yes	No
4.	After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?	Yes	No
5.	Does having a few drinks help decrease your shakiness or tremors?	Yes	No
6.	Does alcohol sometimes make it hard for you to remember parts of the day or night?	Yes	No
7.	Do you have rules for yourself that you won't drink before a certain time of the day?	Yes	No
8.	Have you lost interest in hobbies or activities you used to enjoy?	Yes	No
9.	When you wake up in the morning, do you ever have trouble remembering part of the night before?	Yes	No
10.	Does having a drink help you sleep?	Yes	No
11.	Do you hide your alcohol bottles from family members?	Yes	No
12.	After a social gathering, have you ever felt embarrassed because you drank too much?	Yes	No
13.	Have you ever been concerned that drinking might be harmful to your health?	Yes	No
14.	Do you like to end an evening with a night cap?	Yes	No
15.	Did you find your drinking increased after someone close to you died?	Yes	No
16.	In general, would you prefer to have a few drinks at home rather than go out to social events?	Yes	No
17.	Are you drinking more now than in the past?	Yes	No
18.	Do you usually take a drink to relax or calm your nerves?	Yes	No
19.	Do you drink to take your mind off your problems?	Yes	No
20.	Have you ever increased your drinking after experiencing a loss in your life?	Yes	No
21.	Do you sometimes drive when you had too much to drink?	Yes	No
22.	Has a doctor or nurse ever said they were worried or concerned about your drinking?	Yes	No

Veterans Home of California (VHC) Admission Application

Michigan Alcohol Screening Test - Geriatric

(MAST-G Screening Device – **University of Michigan 1991)**

C

23. Have you ever made rules to manage your drinking?	Yes	No
24. When you feel lonely does having a drink help?	Yes	No

I answered these questions myself.	Yes	No
I had help answering these questions.	Yes	No

_____

Applicant's Signature

_____

Preparer's Signature

Additional comments you wish to make:

_____

_____

_____

_____

_____

_____

_____

_____

Veterans Home of California (VHC) Admission Application

DRUG ABUSE SCREENING TEST (DAST)

D

(Reprinted with permission from Elsevier Science)

Part of your application to the Veterans Home will be a review of your use of non-prescription medications or drugs. Please answer all of the following questions as they apply to you any time over the past 5 years.

Applicant name:_____ Date:_____

1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Do you abuse drugs on a continuous basis?	Yes	No
7.	Do you try to limit your drug use to certain situations?	Yes	No
8.	Have you had “blackouts” or “flashbacks” as a result of drug use?	Yes	No
9.	Do you ever feel bad about your drug abuse?	Yes	No
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
11.	Do your friends or relatives know or suspect you abuse drugs?	Yes	No
12.	Has drug abuse ever created problems between you and your spouse?	Yes	No
13.	Has any family member ever sought help for problems related to drug use?	Yes	No
14.	Have you ever lost friends because of your use of drugs?	Yes	No
15.	Have you ever neglected your family or missed work because of your use of drugs?	Yes	No
16.	Have you ever been in trouble at work because of drug abuse?	Yes	No
17.	Have you ever lost a job because of unusual behavior while under the influence of drugs?	Yes	No
18.	Have you gotten into fights when under the influence of drugs?	Yes	No
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	Yes	No
20.	Have you ever been arrested for driving while under the influence of drugs?	Yes	No
21.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
22.	Have you been arrested for possession of dangerous drugs?	Yes	No
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	Yes	No
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

Veterans Home of California (VHC) Admission Application

DRUG ABUSE SCREENING TEST (DAST)

D

(Reprinted with permission from Elsevier Science)

25. Have you ever gone to anyone for help for a drug problem?	Yes	No
26. Have you ever been in a hospital for medical problems related to drug use?	Yes	No
27. Have you ever been involved in a treatment program specifically related to drug care?	Yes	No
28. Have you been treated as an outpatient for problems related to drug use?	Yes	No

I answered these questions myself	Yes	No
I had help answering these questions	Yes	No

Applicant's Signature

Preparer's Signature

Additional comments you wish to make:

Veterans Home of California (VHC) Admission Application

DECLARATIONS

E

Name_____Social security number_____

Read and initial each appropriate block, then sign your name at the end of this document.

1. Initial here_____I am a bona fide resident of the state of California.

2. Initial here_____I understand that if I am approved for admission to the Veterans Home of California, I will disclose all sources and the amount of my income, including increases and decreases, on an ongoing basis. The Department of Veterans Affairs of the state of California has the right to investigate my financial affairs and I consent to such an investigation.

3. Initial here_____I understand that if I am admitted to the Veterans Home of California, admission will be on a conditional basis for the first 60 days of my residence. If I am discharged from the Veterans Home of California during the first 60 days of my residence, I understand that it will be my responsibility to arrange and pay for transportation from the Veterans Home of California to wherever I wish to go.

4. Initial here_____If I am admitted to the Veterans Home of California, I agree to pay the prescribed amount of fees as set forth by California law.

5. Initial here_____If I am admitted to the Veterans Home of California, reside at the required level of care, and I receive aid and attendance from the U. S. Department of Veterans Affairs and I have no dependents, I understand that I must pay the entire amount of my aid and attendance to the Veterans Home of California.

6. Initial here_____I understand that as a condition of admission and continuing residency, I will, if eligible, apply for and maintain coverage in a federal, state, or private health insurance plan. As long as I am able and eligible, I will maintain this health coverage based on the direction of the Home's Finance Office.

7. Initial here_____I have fully disclosed the details of the following:

   A. Medical history, including any and all medical treatments;
   B. Psychiatric treatment or counseling;
   C. History or current substance abuse problems;
   D. Criminal convictions, probation, parole or mandatory county registration.

---

8. COLLECTION OF COST-OF-CARE IN EXCESS OF RESIDENT FEES

Military and Veterans Code Sections 1035 and 1035.05 provide that, upon the death of a resident of the Home, any money or personal property of that resident will first be paid to the Administrator of the Home to cover payment of funeral expenses or any obligation owed to the Home, *including* the cost of any care rendered by the Home in excess of the fees paid by the resident to the Home. The cost of care in excess of resident fees is often referred to as the *un-reimbursed cost-of-care*. If you are a resident of a California Veterans Home at the time of your death, the Home may disburse your money and/or personal property to the extent there are un-reimbursed costs of care at the time of your death.

CALCULATION OF THE UN-REIMBURSED COSTS OF CARE

The *un-reimbursed cost-of-care* is the difference between all resident account cost items and resident account cost offset items (reimbursements). Below is a brief description of how the un-reimbursed cost-of-care is calculated with examples of costs of care in excess of resident fees frequently incurred by residents and sources of reimbursements. (See also, California Code of Regulations, title 12, sections 506 and 507.)

A. COSTS OF CARE:

I. Room and Board Charges

The Room and Board Charges are the per-diem charges based on a resident's level of care and admission status for all services provided by the Home. The rate varies based on the level of care the resident receives and whether or not that resident is present at the Home. There could also be a difference in the cost of residence between the three California Veterans Homes. An example would be (current rates may vary) if you come into the Home at an independent level of care the cost would be $95 and cost for the initial nursing level of care could be $140 a day.

The rate changes based on whether or not the person is physically present at the Home or not. This is because some of the costs associated with residence are fixed and are incurred regardless of whether the resident is physically present at the Home. When away from the Home you will be charged the lower daily "leave rate." An example would be (current rates may vary) if you are present and in independent level of care the cost would be about $95/day but if you were away on vacation the cost would be $47.50/day.

II. Outside Medical Expenditures

Outside medical expenditures include any amount paid on behalf of a resident to a health care provider outside of the Veterans Home. Typically this includes any medical and dental services ***for which the resident has no insurance and/or is not covered by Medicare or Medi-Cal***.

III. Other Medical Expenditures

This category of cost items includes co-payments or deductibles paid by the Home for treatment covered under the resident's medical insurance.

IV. Other Debits: Such as funeral expense or unpaid bills.

B. CALCULATION OF RESIDENT ACCOUNT COST OFFSET ITEMS (REIMBURSEMENTS)

I. Resident Fees Paid

This would include any fees paid by or on behalf of a resident that are authorized by Military and Veterans Code section 1012.3.

II. Aid and Attendance (A&A) Payments

For residents who receive an aid and attendance allowance from the United States Veterans Administration pursuant to 38 U.S.C. §§1502(b), 1521(d), and who have no dependent spouse, child, grandchild, or parent, the allowance is paid to the Veterans Home. All such payments remitted to the Home are used to reduce the un-reimbursed cost-of-care.

III. Veterans Administration Per Diem Payments

This item consists of payments from the United States Department of Veterans Affairs pursuant to 38 U.S.C. §1741 for the care of veterans at the Home. As the name implies, the payments are based on a daily rate. Like the cost-of-care above, the amount of these payments is based on the level of care provided to the resident.

IV. Funds Received from Outside Sources

These would include any amounts received by the home for the benefit of the particular resident that do not fit into one of the above categories. Examples would include Medi-Cal, Medicare, supplemental insurance payments and any other voluntary payment, collection or net liquidation of assets received from external sources on behalf of a resident.

C. QUARTERLY STATEMENTS

Pursuant to Military and Veterans Code section 1035.6, each resident will receive a quarterly accounting statement of the total excess costs of care accrued to date. The statement is provided for informational purposes only, and is not a bill to be paid at the time of receipt. The **Exhibit A** of this section contains an ***example*** of the quarterly statements provided to residents of the Veterans Homes.

D. RESIDENTS WHO HAVE NO WILL AND NO HEIR AT THE TIME OF DEATH

If a resident of a Veterans Home dies without leaving a will or any heirs, any money or personal property in his or her estate will become the property of the Home and will be credited to the Morale, Welfare and Recreation Fund. (Military and Veterans Code section 1035.05)

E. ADVICE TO SEEK LEGAL COUNSEL

If you are concerned about the effect of Military and Veterans Code section 1035 and 1035.05 on your estate and would like to obtain guidance on how to protect you assets, you are advised to obtain counsel from a legal expert of your choosing at your own expense.

Initial here_____*I have read the foregoing Notification of Costs of Care in Excess of the Resident Fees and understand that, should I die while a resident of the Home, the Veterans Home of California shall use all money and personal property belonging to me, to pay for funeral expenses and all costs of care rendered to me by the Home in excess of the fees I paid, and that this property and money will not be available to my heirs until such time as my funeral expenses and un-reimbursed costs of care have been paid. I also understand that if I die while a resident of the Home and do not have any heirs or a will at the time of my death, my estate will become the property of the Home and will be credited to the Morale, Welfare and Recreation Fund. I acknowledge that I have been advised of my right to seek legal counsel of my own choosing and at my own expense for purposes of determining the possible effect of the Military and Veterans Code section 1035 and 1035.05 on my estate and to obtain guidance on how to protect my assets.*

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DECLARATIONS

E

The information provided in this application has been provided for the purpose of obtaining admission to the Veterans Home of California. I understand that if any information is found to be incorrect or incomplete that I may be denied admission to the Veterans Home of California.

I declare under the penalty of perjury of the laws of the state of California that the information provided herein is true and correct to the best of my knowledge and belief.

I authorize the California Department of Veterans Affairs (CDVA), its employees, officers, agents or designees to verify the information that has been provided in this application. I further authorize the U.S. Department of Veterans Affairs, the Department of Defense, the California Franchise Tax Board and any applicable law enforcement agency to release information about me to CDVA with the understanding that CDVA shall keep such information confidential.

Executed at County of:_____ State of:_____

Date_____ Signature_____

Witness signature_____

Print witness name_____

Witness address_____

Exhibit A
EXAMPLE ONLY

COSTS OF CARE IN EXCESS OF THE RESIDENT FEES

Date: June 30, 2004
Name: John Q. Veteran
Address: Veterans Home of California—Chula Vista
Room B-26

Social Security No.: 123-45-6789
Period of Stay: April 1, 2003 through June 30, 2004

Resident Account Cost Items

Room and Board (SNF: 455 days @ $175 per day)	$79,625.00
Funeral Expenses	$0.00
Other Debts (e.g. Fees Owed)	$0.00
Outside medical cost	$1,200.00
Total Cost	$80,825.00

Resident Account Cost Offset Items

Insurance Payments	$500.00
Balance of Trust Account (Inside Money)	$0.00
Veterans Administration Per Diem Payments ($50.55 per day for 455 days)	$23,000.25
Resident Fee Payments (15 months at $2,000 per month)	$30,000.00
Aid and Attendance Payments	$15,000.00
Total Cost Offsets	$68,500.25
Net Un-reimbursed Cost-of-care	$12,324.75

THIS IS NOT A BILL

Veterans Home of California (VHC) Admission Application

Social Functioning Assessment

F

A FAMILY MEMBER, FRIEND, VETERANS SERVICE OFFICER OR SOCIAL WORKER WHO KNOWS YOU PERSONALLY MUST COMPLETE THIS FORM.

1. Applicant's name _____
   Last First Middle
   Social Security number _____ Date of birth _____

2. Applicant's next-of-kin _____ Relationship _____
   Address _____
   Daytime phone number _____ Evening phone number _____

3. Where is the applicant living?
   - ☐ Home ☐ Hospital ☐ ICF (Assisted Living)
   - ☐ Homeless ☐ Board and care ☐ SNF (Nursing Home)
   - ☐ Other (specify) _____

   Address _____
   Who lives with him/her? _____

4. Check the activities of daily living applicant can do **WITHOUT** assistance: (check all that apply)

☐ Dressing	☐ Prepare meals	☐ Care for their property
☐ Eating	☐ Read/Write	☐ Use community resources
☐ Walking or standing	☐ Follow verbal orders	
☐ Toileting	☐ Follow written orders	☐ Live alone
☐ Hygiene and grooming	☐ Carry on a conversation	☐ Drive a motor vehicle
☐ Bathing/Showering		☐ Make/keep med. appt.
☐ Housecleaning	☐ Taking medications	☐ Other _____
☐ Laundry	☐ Handling money	

5. Has the applicant completed an Advanced Health Care Directive? ☐ Yes ☐ No

_____
Name of appointed Health Care Agent Address Phone number

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Social Functioning Assessment

F

6. Does the applicant have a court -appointed: Conservator of Person? ☐ Yes ☐ No
   Conservator of Estate? ☐ Yes ☐ No

   _____
   Name of court-appointed Conservator Address Phone number

   Please provide a copy of your court documents appointing you as conservator.

7. Does anyone handle his/her financial or personal affairs? ☐ Yes ☐ No

   _____
   Name Address Phone number

8. Applicant's current hobbies, clubs, groups, veterans' organizations and other interests?

   _____

   _____

9. Check descriptions of applicant's behaviors: (check all that apply)

☐ Socially withdrawn	☐ Sexually inappropriate	☐ Angry
☐ Shy	☐ Hostile	☐ Short temper
☐ Happy	☐ Boisterous	☐ Outgoing
☐ Friendly	☐ Forgetful	☐ Sad
☐ Quiet	☐ Moody	

   ☐ Other (describe):_____

10. Describe typical daily activities
    A. Morning_____
    B. Afternoon_____
    C. Evening_____
    D. Night_____

11. Any additional information/comments

    _____

    _____

    _____

    _____

Veterans Home of California (VHC) Admission Application

Social Functioning Assessment

F

I certify that the answers to the foregoing questions are true, correct and complete to the best of my personal knowledge and belief.

Executed at _____ County _____ State _____

Name (print)_____ Signature_____

Street address_____ City/State/Zip_____

Phone number_____ Length applicant known_____

Relationship_____ Date signed_____

Veterans Home of California (VHC) Admission Application

Physician's Medical Certificate

G

This section to be completed by a physician and is designed to assess the resource needs for health care of the patient.

THIS CERTIFICATION IS VALID FOR **THREE MONTHS**. ALL INFORMATION MUST BE CURRENT AND COMPLETE TO AVOID DELAYS IN PROCESSING YOUR PATIENT'S APPLICATION.

SECTION I: HISTORY AND PHYSICAL EXAM

1. Applicant's full name_____
   Last First Middle
2. Date of birth_____Age _____
3. Date of exam_____
4. Are you currently treating this applicant? ☐ Yes ☐ No
5. How long have you known this applicant?_____Years/_____Months/ or_____Days
6. Upon arrival patient was: ☐ Ambulatory or ☐ Non-Ambulatory and then using a:
   ☐ Manual Wheelchair ☐ Electric Mobility ☐ Walker ☐ Cane
   Was the device ☐ medically necessary or ☐ convenience?
7. Current Medical Diagnoses:

☐ Diabetes ☐ CHF ☐ CAD ☐ Hypertension ☐ Emphysema
☐ Glaucoma ☐ Chronic Psychosis ☐ Other(s), please comment below:

_____
_____
_____
_____
_____

8. Pertinent history including hospitalizations:

_____
_____
_____

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9. Alcohol Use History ☐ Yes ☐ No If Yes, comment below:

_____

_____

10. Allergies ☐ Drug(s) ☐ Food(s) ☐ Environmental

Restrictions associated with allergies:_____

_____

_____

11. Swallowing Disorder Precautions

_____

12. List current medications or attach list separately:

_____

_____

_____

_____

13. Patient takes medication responsibly. ☐ Yes ☐ No

14. Physical examination or attach most current H & P separately:

Vital Signs: Ht_____Wt_____T_____P_____R_____BP_____

Current Pain Scale (1=no pain, 10=max): 1 2 3 4 5 6 7 8 9 10

Location of Pain_____

General Appearance (Enter Significant Findings Only):

HEENT:_____ ☐ No Findings

Neck:_____ ☐ No Findings

Lungs:_____ ☐ No Findings

Breast:_____ ☐ No Findings

Cardiac:_____ ☐ No Findings

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Abdomen: _____ ☐ No Findings

Back: _____ ☐ No Findings

GU or GYN: _____ ☐ No Findings

Extremities: _____ ☐ No Findings

Neurologic: _____ ☐ No Findings

Skin: _____ ☐ No Findings

SECTION II: COGNITIVE ASSESSMENT

1. Level of consciousness:

   Alert ☐ Yes ☐ No Comments _____

   Withdrawn ☐ Yes ☐ No Comments _____

   Confused ☐ Yes ☐ No Comments _____

2. Oriented as to: ☐ Person ☐ Place ☐ Time

3. Memory impairment: ☐ Mild ☐ Moderate ☐ Severe

4. History of wandering behavior, gets lost: ☐ Yes ☐ No

   Comments _____

5. Communication ability:

Can speak	☐ Yes ☐ No	Understands speech	☐ Yes ☐ No
Can write	☐ Yes ☐ No	Speaks clearly	☐ Yes ☐ No
Can hear	☐ Yes ☐ No	Understands writing	☐ Yes ☐ No
Wears devices	☐ Yes ☐ No	Understands gestures	☐ Yes ☐ No

(if yes, describe) _____

6. Vision: ☐ No significant issues
☐ Impaired/Low Vision
☐ Legally Blind
☐ Uses Low Vision Devices (describe)_____
_____
☐ Completed Low Vision or Blind Rehab (Where/Date)_____
_____

SECTION III: BEHAVIORAL HEALTH ASSESSMENT

1. Personality or behavioral problems that may affect their ability to live in a communal setting:
☐ Yes ☐ No If yes, please explain:_____
_____
_____
_____

2. History of alcohol or drug abuse: ☐ Yes ☐ No, Go to #3
If yes: Has patient received treatment? ☐ Yes ☐ No
If yes, give dates and where:_____
_____
_____
Does patient continue to abuse? ☐ Yes ☐ No
If not, length of sobriety:_____

3. History of falling or injury secondary to falls: ☐ Yes ☐ No
If yes, explain:_____

4. Additional Comments relative to person's ability to live safely in a communal setting:
_____
_____
_____
_____

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SECTION IV: PHYSICIAN'S ASSESSMENT FOR DAILY LIVING ACTIVITIES

PLEASE CHECK **ALL** APPROPRIATE BOXES BELOW

Bathing

- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance
- ☐ Requires prompting

Grooming

- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance
- ☐ Requires prompting

Dressing

- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance
- ☐ Requires prompting

Feeding

- ☐ Completely independent
- ☐ Needs assistance
- ☐ Must be fed
- ☐ Has swallowing disorder
- ☐ Requires prompting

Medication

- ☐ Needs assistance
- ☐ Incapable of taking own meds
- ☐ Able to take own medication
- ☐ Requires prompting for compliance

Ambulation

- ☐ Can walk 100 yards
- ☐ Recurrent Falls
- ☐ Can climb stairways—one floor
- ☐ Can climb stairways—two floors

Mobility

- ☐ No Devices
- ☐ Cane
- ☐ Walker
- ☐ Electric Mobility

Transfers (bed/wheelchair)

- ☐ Independent
- ☐ Needs assist
- ☐ Prompting for safe transfer

Toileting

- ☐ Completely independent
- ☐ Needs assist
- ☐ Needs prompting
- ☐ Elimination devices needed
  - ☐ External catheter
  - ☐ Indwelling catheter
  - ☐ Colostomy
  - ☐ Other:_____

Incontinence:

Bladder	Bowel
☐ Independent	☐ Independent
☐ Needs assist	☐ Needs assist
☐ Needs prompt	☐ Needs prompt

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PHYSICIAN INFORMATION

I certify that the answers to the foregoing questions are true, correct and complete to the best of my personal knowledge and belief.

_____

Executed at County State

Physician's name (Print)_____

Signature_____

I am a: ☐ Physician ☐ Nurse Practitioner ☐ Physician Assistant

Address_____

Telephone_____ Fax_____

Date signed_____